Northwest Nazarene University
Stand Alone Vision
Effective Date: August 1, 2014
Amendments Attached

Benefit Period: August 1 through July 31

Form #3-405A (11/09) with dep age amend; 01/12 amends; 08-12 amends; 04-13 amends; 01-14 amends

An Independent Licensee of the Blue Cross and Blue Shield Association
AMENDMENTS

The following amendment has been made to your Group Policy effective January 1, 2014. Please read it carefully.

The POLICY shall be amended to reflect the following revisions:

The Subrogation and Reimbursement Rights of Blue Cross of Idaho section in the General Provisions Section has been changed to the following:

SUBROGATION AND REIMBURSEMENT RIGHTS OF BLUE CROSS OF IDAHO

The benefits of this Policy will be available to an Insured when he or she is injured, suffers harm or incurs loss due to any act, omission, or defective or unreasonably hazardous product or service of another person, firm, corporation or entity (hereinafter referred to as “third party”). To the extent that such benefits for Covered Services are provided or paid for by Blue Cross of Idaho under this Policy or any other Blue Cross of Idaho plan, agreement, certificate, contract or policy, Blue Cross of Idaho shall be subrogated and succeed to the rights of the Insured or, in the event of the Insured’s death, to the rights of his or her heirs, estate, and/or personal representative.

As a condition of receiving benefits for Covered Services in such an event, the Insured or his or her personal representative shall furnish Blue Cross of Idaho in writing with the names and addresses of the third party or parties that caused or are responsible, or may have caused or may be responsible for such injury, harm or loss, and all facts and information known to the Insured or his or her personal representative concerning the injury, harm or loss.

Blue Cross of Idaho may at its option elect to enforce either or both of its rights of subrogation and reimbursement.

Subrogation is taking over the Insured’s right to receive payments from other parties. The Insured or his or her legal representative will transfer to Blue Cross of Idaho any rights he or she may have to take legal action arising from the injury, harm or loss to recover any sums paid on behalf of the Insured. Thus, Blue Cross of Idaho may initiate litigation at its sole discretion, in the name of the Insured, against any third party or parties. Furthermore, the Insured shall fully cooperate with Blue Cross of Idaho in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice Blue Cross of Idaho’s subrogation rights and efforts. Blue Cross of Idaho will be reimbursed in full for all benefits paid even if the Insured is not made whole or fully compensated by the recovery. Moreover, Blue Cross of Idaho is not responsible for any attorney’s fees or other expenses or costs incurred by the Insured without prior written consent of Blue Cross of Idaho and, therefore, the “common fund” doctrine does not apply to any amounts recovered by any attorney the Insured hires regardless of whether amounts recovered are used to repay benefits paid by Blue Cross of Idaho, or otherwise.

Additionally, Blue Cross of Idaho may at its option elect to enforce its right of reimbursement from the Insured, or his or her legal representative, of any benefits paid from monies recovered as a result of the injury, harm or loss. The Insured shall fully cooperate with Blue Cross of Idaho in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice Blue Cross of Idaho’s reimbursement rights and efforts.

The Insured shall pay Blue Cross of Idaho as the first priority, and Blue Cross of Idaho shall have a constructive trust and an equitable lien on, all amounts from any recovery by suit, settlement or otherwise from any third party or parties or from any third party’s or parties’ insurer(s), indemnitor(s) or underwriter(s), to the extent of benefits provided by Blue Cross of Idaho under this Policy, regardless of how the recovery is allocated (i.e., pain and suffering) and whether the recovery makes the Insured whole. Thus, Blue Cross of Idaho will be reimbursed by the Insured, or his or her legal representative, from monies recovered as a result of the injury, harm or loss, for all benefits paid even if the Insured is not made whole or fully compensated by the recovery. Moreover, Blue Cross of Idaho is not responsible for any attorney’s fees or other expenses or costs incurred by the Insured without prior written consent of Blue Cross of Idaho and, therefore, the “common fund” doctrine does not apply to any amounts recovered by any attorney the Insured hires regardless of whether amounts recovered are used to repay benefits paid by Blue Cross of Idaho, or otherwise.

To the extent that Blue Cross of Idaho provides or pays benefits for Covered Services, Blue Cross of Idaho’s rights of subrogation and reimbursement extend to any right the Insured has to recover from the Insured’s insurer, or under the Insured’s “Medical Payments” coverage or any “Uninsured Motorist,” “Underinsured Motorist,” or other similar coverage provisions, and workers’ compensation benefits.

Form No. 18-158 (01/14) Subrogation Amendment
Blue Cross of Idaho shall have the right, at its option, to seek reimbursement from, or enforce its right of subrogation against, the Insured, the Insured’s personal representative, a special needs trust, or any trust, person or vehicle that holds any payment or recovery from or on behalf of the Insured including the Insured’s attorney.

Blue Cross of Idaho’s subrogation and reimbursement rights shall take priority over the Insured’s rights both for expenses already incurred and paid by Blue Cross of Idaho for Covered Services, and for benefits to be provided or payments to be made by Blue Cross of Idaho in the future on account of the injury, harm or loss giving rise to Blue Cross of Idaho’s subrogation and reimbursement rights. Further, Blue Cross of Idaho’s subrogation and reimbursement rights for incurred expenses and/or future expenses yet to be incurred are primary and take precedence over the rights of the Insured, even if there are deficiencies in any recovery or insufficient financial resources available to the third party or parties to totally satisfy all of the claims and judgments of the Insured and Blue Cross of Idaho.

Collections or recoveries made in excess of such incurred Blue Cross of Idaho expenses shall first be allocated to such future Blue Cross of Idaho expenses, and shall constitute a special Deductible applicable to such future benefits and services under this or any subsequent Blue Cross of Idaho policy. Thereafter, Blue Cross of Idaho shall have no obligation to make any further payment or provide any further benefits until the benefits equal to the special Deductible have been incurred, delivered, and paid by the Insured.

Except as amended, the Master Group Policy and Enrollee Certificate shall remain unchanged.

In witness whereof, BLUE CROSS OF IDAHO HEALTH SERVICE, INC., by its duly authorized officer, has executed this amendment.

Blue Cross of Idaho
Health Service, Inc.
PO Box 7408
Boise, ID  83707

Rex Warwick, CHC
Vice President, Sales
Blue Cross of Idaho

Form No. 18-158 (01/14) Subrogation Amendment
AMENDMENTS

The following amendment has been made to your Group Policy effective with your renewal. Please read it carefully.

The **BENEFITS OUTLINE** shall be amended to reflect the following revisions:

1. The following language shall be amended in the Benefits Outline:

   *The Participating VSP Doctor is responsible for verifying benefits with VSP prior to rendering services. An Insured must provide the VCSV Participating Provider sufficient information to verify eligibility. Failure of the Insured to provide sufficient information may delay services and may affect benefit payment under this Policy.*

The **POLICY** shall be amended to reflect the following revisions:

The **VISION BENEFITS SECTION** shall be amended as follows:

1. In the **Vision Care Benefits Section**, item III.A. shall be amended as follows:

   **III. Procedures for Obtaining Covered Services**
   
   An Insured must contact the Vision Care Services Vendor (VCSV) Participating Provider to make an appointment to receive Covered Services. No preauthorization or special benefit form is required. The doctor is responsible for verifying eligibility and obtaining the necessary authorization from the VCSV prior to the delivery of service. Each authorization is valid for fifteen (15) days. An Insured must provide the VCSV Participating Provider sufficient information to verify eligibility. Failure of the Insured to provide sufficient information may delay services and may affect benefit payment under this Policy.

The **DEFINITIONS SECTION** will be amended as follows:

1. The definition of “**Totally Disabled (or Total Disability)” shall be removed.**

The **GENERAL PROVISIONS SECTIONS** shall be amended as follows:

1. Item XIX. of the **INQUIRY AND APPEALS PROCEDURES** section shall now read:

   **Inquiry And Appeals Procedures**
   
   **A. Informal Inquiry**
   
   For any initial questions concerning a claim, an Insured should call the VCSV phone number listed on the back of the Insured’s Blue Cross of Idaho ID card.

   **B. Formal Appeal**
   
   An Insured who wishes to formally appeal a Pre-Service Claim decision by BCI may do so through the following process:
1. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. Urgent claim appeals, and the documents in support of such appeals may be submitted by phone or facsimile. The appeal should set forth the reasons why the Insured contends BCI’s decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.

2. After receipt of the appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed by a BCI Medical Director, physician designee, or a VCSV designee. For non-urgent claim appeals, BCI or a VCSV designee will mail a written reply to the Insured within fifteen (15) days after receipt of the written appeal. Urgent claim appeals will be notified orally within seventy-two (72) hours. If the original decision is upheld, the reply will state the specific reasons for denial and the specific provisions on which the decision is based. Each appeal will be processed as quickly as possible taking into account the medical exigencies of each claim.

3. Furthermore, the Insured or their authorized representative has the right to reasonable access to, and copies of all documents, records, and other information that are relevant to the appeal.

4. If the original, non-urgent claim decision is upheld upon reconsideration, the Insured may send an additional written appeal to the Appeals and Grievance Coordinator requesting further review. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within thirty (30) days of BCI’s or its VCSV designee’s mailing of the initial reconsideration decision. A BCI Medical Director or its VCSV designee who is not subordinate to the Medical Director or physician designee who decided the initial appeal, will issue a final decision after consideration of all relevant information. A final decision on the appeal will be made within fifteen (15) days of its receipt.

C. An Insured who wishes to formally appeal a Post-Service Claims decision by BCI may do so through the following process:

1. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. This written appeal should set forth the reasons why the Insured contends BCI’s or a VCSV designee’s decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.

2. After receipt of the written appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed by a Medical Director or physician designee if the appeal requires medical judgment. BCI or a VCSV designee shall mail a written reply to the Insured within thirty (30) days after receipt of the written appeal. If the original decision is upheld, the reply will list the specific reasons for denial and the specific provisions on which the decision is based. Each appeal will be processed as quickly as possible.

3. Furthermore, the Insured or their authorized representative has the right to reasonable access to, and copies of all documents, records, and other information that are relevant to the appeal.

4. If the original decision is upheld upon reconsideration, the Insured may send an additional written appeal to the Appeals and Grievance Coordinator requesting further review. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within sixty (60) days of BCI’s (or a VCSV designee’s) mailing of the initial reconsideration decision. A BCI Medical Director who is not subordinate to the Medical Director, physician designee, or a VCSV designee who decided the initial appeal, will issue a final decision after consideration of all relevant information, if the appeal requires medical judgment. A final decision on the appeal will be made within thirty (30) days of its receipt. If the appeal does not require medical judgment, a BCI Vice President who did not decide the initial appeal will issue the decision.
D. **External Review**

At BCI’s discretion, an additional review is available for Adverse Benefit Determinations based upon medical issues including medical necessity and investigational treatment. An Insured must first exhaust both levels of the formal appeals process before submitting a request for External Review to the Appeals and Grievance Coordinator. A request for External Review must be sent within sixty (60) days of the date of Blue Cross of Idaho’s second formal written appeal decision. External Review will be made by an impartial provider, associated with an independent review organization, who practices in the same or a similar specialty as the one involved in the review. The Independent Review Organization will issue a determination within sixty (60) days of receipt of the request for External Review.

Submission of an appeal for External Review is voluntary and does not affect an Insured’s right to file a civil action under section 502(a) of the Employee Retirement Income Security Act (ERISA) following the exhaustion of the formal appeals process, except that the time to file such action shall be tolled while the External Review is pending.

2. **Item XXVI.** of the **REPLACEMENT COVERAGE** section shall now read:

If this Policy replaces prior group coverage within sixty (60) days of the date of termination of prior coverage, BCI shall immediately cover all employees and dependents validly covered under the prior coverage at the date of termination who meet BCI’s eligibility requirements and who would otherwise be eligible for coverage under this Policy, regardless of any exclusions or limitations relating to active employment or nonconfinement.

Except as amended, the Master Group Policy and Enrollee Certificate shall remain unchanged.

In witness whereof, BLUE CROSS OF IDAHO HEALTH SERVICE, INC., by its duly authorized officer, has executed this amendment.

Blue Cross of Idaho
Health Service, Inc.
PO Box 7408
Boise, ID 83707

Rex Warwick, CHC
Vice President, Sales
Blue Cross of Idaho

Rex Warwick, CHC
Vice President, Sales
Blue Cross of Idaho
AMENDMENTS

The following amendment has been made to your Group Policy effective August 2012. Please read it carefully.

The GENERAL PROVISIONS SECTION shall be amended as follows:

1. Item III.C. of the General Provisions Section shall now read:

   C. If the Group fails to pay premiums as agreed in the Eligibility and Enrollment Section, this Policy will terminate without notice at the end of the period for which the last premiums were paid. This Policy does not have a grace period; however, if the Group makes payment of the premiums within thirty (30) days after the due date, BCI will reinstate this Policy as of the due date. No benefits are available during this thirty (30)-day period unless all premiums are properly paid before expiration of the thirty (30)-day period. BCI reserves the right to apply fee of Prime Interest Rate plus two percent (2%) annualized interest on any portion of the balance owed by the Group to BCI that remains unpaid thirty (30) days or more beyond the original due date.

Except as amended, the Master Group Policy and Enrollee Certificate shall remain unchanged.

In witness whereof, BLUE CROSS OF IDAHO HEALTH SERVICE, INC., by its duly authorized officer, has executed this amendment.

Blue Cross of Idaho
Health Service, Inc.
PO Box 7408
Boise, ID 83707

Rex Warwick, CHC
Vice President, Sales
Blue Cross of Idaho

Form No. 18-017 (08/12) – Stand Alone Vision/Voluntary Vision
AMENDMENTS

The following amendment has been made to your Group Policy effective January 2012. Please read it carefully.

The **BENEFITS OUTLINE** shall be amended to reflect the following revisions:

1. The following language shall be added to the Benefits Outline:

   **SPANISH (Español)**: Para obtener asistencia en Español, llame al (208) 331-7347 or (800) 627-1188.
   **TAGALOG (Tagalog)**: Kung kailangan niyo ang tulong sa Tagalog tumawag sa (208) 331-7347 or (800) 627-1188.
   **CHINESE (中文)**: 如果需要中文的帮助，请拨打这个号码 (208) 331-7347 or (800) 627-1188。
   **NAVAJO (Dine)**: Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' (208) 331-7347 or (800) 627-1188.

2. The following language shall be added to the Benefits Outline:

   *The Participating VSP Doctor must verify benefits with VSP prior to rendering services. If that verification does not occur, benefits will be paid as Out-of-Network Services.

The **POLICY** shall be amended to reflect the following revisions:

1. In the **Vision Care Benefits Section**, item **III. A.** shall be amended as follows:

   **III. Procedures For Obtaining Covered Services**
   
   **A.** An Insured must contact the Vision Care Services Vendor (VCSV) Participating Provider to make an appointment to receive Covered Services. No preauthorization or special benefit form is required.

   The doctor is responsible for verifying eligibility and obtaining the necessary authorization from the VCSV prior to the delivery of service. Each authorization is valid for fifteen (15) days. If that verification does not occur, benefits will be paid as out-of-network.

Except as amended, the Master Group Policy and Enrollee Certificate shall remain unchanged.

In witness whereof, BLUE CROSS OF IDAHO HEALTH SERVICE, INC., by its duly authorized officer, has executed this amendment.

Blue Cross of Idaho
Health Service, Inc.
PO Box 7408
Boise, ID 83707

Rex Warwick, CHC
*Vice President, Sales*
Blue Cross of Idaho

Form No. 3-951 (01/12) – Stand Alone Vision - C1
AMENDMENTS

The following amendment has been made to your Group Policy effective October 2010. Please read it carefully.

1. The **Dependent Age** shall now read:

   **B. Eligible Dependent**
   
   To qualify as an Eligible Dependent, a person must be and remain one (1) of the following:
   
   1. The Enrollee’s spouse under a legally valid marriage.
   2. The Enrollee’s natural child, stepchild, legally adopted child, child placed with the Enrollee for adoption, or child for whom the Enrollee or the Enrollee’s spouse has court-appointed guardianship or custody. The child must be:
      a) Under the age of twenty-six (26); or
      b) Medically certified as disabled due to mental handicap or retardation or physical handicap and financially dependent upon the Enrollee for support, regardless of age.
   3. An Enrollee must notify BCI and/or the Group within thirty (30) days when a dependent no longer qualifies as an Eligible Dependent. Coverage for the former Eligible Dependent will terminate the last day of the month in which the change in eligibility occurred.

Except as amended, the Master Group Policy and Enrollee Certificate shall remain unchanged.

In witness whereof, BLUE CROSS OF IDAHO HEALTH SERVICE, INC., by its duly authorized officer, has executed this amendment.

Blue Cross of Idaho
Health Service, Inc.
PO Box 7408
Boise, ID 83707

Rex Warwick, CHC
Vice President, Sales
Blue Cross of Idaho
This Benefits Outline describes the benefits of this Policy in general terms. It is important to read the Policy in full for specific and detailed information that includes additional exclusions and limitations on benefits. Your manager of employee benefits should be able to help if you have questions.

Throughout this Policy, Blue Cross of Idaho may be referred to as BCI. For Covered Services under the terms of this Policy, Maximum Allowance is the amount established by the Vision Care Services Vendor as the highest level of compensation for a Covered Service. There is more detailed information on how Maximum Allowance is determined and how it affects out-of-state coverage in the Definitions Section.

To locate a Participating Provider in your area, please visit our Web site at www.bcidentaho.com. You may also call our Customer Services Department at 208-331-7347 or 800-627-1188 for assistance in locating a Provider.

### ELIGIBILITY AND ENROLLMENT

To qualify as an Eligible Employee under this Policy, a person must be and remain a full-time employee, sole proprietor, or partner of the Group who regularly works at least 20 hours per week and is paid on a regular, periodic basis through the Group’s payroll system.  
*(see the Policy for additional Eligibility and Enrollment provisions)*

### PROBATIONARY PERIOD

The Group will determine if there are certain probationary periods that must be satisfied before a new Eligible Employee can qualify for coverage under this Policy.
### VISION CARE BENEFITS (VSP)

<table>
<thead>
<tr>
<th>For Covered Providers and Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Copayment</strong></td>
<td></td>
</tr>
<tr>
<td>For Glasses</td>
<td>Insured pays $20 per eye exam and prescription glasses.</td>
</tr>
<tr>
<td>For Contacts</td>
<td>Insured pays up to $60 per contact exam and fitting</td>
</tr>
</tbody>
</table>

#### Service Frequency Limitations

Insured may receive one (1) eye exam and/or one (1) pair of Lenses and/or one (1) Frame or one (1) pair of Medically Necessary Contact Lenses (in lieu of eyeglasses) every twelve (12) months.

#### Payment for Services Rendered:

##### Participating VSP Doctor

<table>
<thead>
<tr>
<th>Exam</th>
<th>BCI pays 100% after Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescription Glasses</strong></td>
<td>Basic Lenses and Medically Necessary Contact Lenses are covered in full. Frame allowance of $130, and 20% off any out-of-pocket expenses.</td>
</tr>
<tr>
<td><strong>Elective Contacts</strong></td>
<td>Exam and fitting are covered at 100% after Copayment. Includes an allowance of $130 for materials in place of benefits for Prescribed Lenses and Frames. 15% discount off the contact lens exam.</td>
</tr>
</tbody>
</table>

##### Nonparticipating VSP Doctor

<table>
<thead>
<tr>
<th>Professional Fees</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Exam</td>
<td>$50</td>
</tr>
<tr>
<td><strong>Materials—lenses per pair</strong></td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>$50</td>
</tr>
<tr>
<td>Bifocals, up to</td>
<td>$75</td>
</tr>
<tr>
<td>Trifocals, up to</td>
<td>$100</td>
</tr>
<tr>
<td>Frame, up to</td>
<td>$70</td>
</tr>
<tr>
<td><strong>Contact Lenses— per pair</strong></td>
<td>(evaluation, materials, and fittings only)</td>
</tr>
<tr>
<td>Medically Necessary, up to Maximum Allowance</td>
<td>$105</td>
</tr>
<tr>
<td></td>
<td>$210</td>
</tr>
</tbody>
</table>
Stand Alone Vision Group Policy And Enrollee Certificate

STAND ALONE VISION GROUP POLICY

FOR

Northwest Nazarene University

Group #10030804

Effective Date: August 1, 2014
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GROUP APPLICATION AND ACCEPTANCE

Northwest Nazarene University, called the Group, hereby confirms that it has previously applied for and been furnished coverage by Blue Cross of Idaho Health Service, Inc., called Blue Cross of Idaho.

The Group acknowledges it has received 40 days advance written notice of modification of the Policy as required by General Provision III.A. and that the attached Policy reflects the modification. The Group agrees to accept this Policy and signifies its acceptance by payment of its August 1, 2014 premium. The Group further agrees that this Policy shall supersede all previous contracts, certificates or agreements issued by Blue Cross of Idaho, but that the group enrollment agreement or master group application, whichever document was previously submitted by the Group, shall continue in force.

Blue Cross of Idaho agrees, in consideration of the group enrollment agreement or master group application and premium payments when due, and subject to all the terms of this Policy, to provide each Member of the Group the benefits of this Policy, beginning on August 1, 2014 and continuing on a month-to-month basis thereafter, unless modified or terminated as provided by this Policy.

Rex Warwick, CHC  
Vice President, Sales  
Blue Cross of Idaho  

July 23, 2014
HOW TO SUBMIT CLAIMS

An Insured must submit a claim to BCI’s designated Vision Care Services Vendor (VCSV), Vision Service Plan (VSP) in order to receive benefits for Covered Services. There are two (2) ways for an Insured to submit a claim:

1. The vision service Provider can file the claim for the Insured. Most Providers will submit a claim on an Insured's behalf if the Insured shows them a BCI identification card and tells them they have coverage through VSP.

2. The Insured can send the claim to VSP.

To File an Insured's Own Claims

Most In-Network (Participating) vision service Providers will submit a claim for the Insured. If the Insured receives services from an Out-of-Network (Nonparticipating) vision service Provider, the Insured can file the claim directly to VSP. To submit an Out-of-Network claim:

1. The Insured can visit VSP’s Web site at www.vsp.com and sign on under the “Members & Consumers” section. Click on the “Out of Network Reimbursement” link under “My Forms.” Once completed, mail the form to VSP at the address listed below.

2. Make a copy of the itemized billing statement, provide the following information, and mail to the address listed below.
   a. Insured & Patient Name (first and last)
   b. Patient Date of Birth
   c. Date of Service
   d. Address & Phone Number

VSP
P.O. Box 997105
Sacramento, CA 95899

For assistance with claims the Insured can call VSP Customer Service at 1-800-877-7195 Monday through Friday 6 a.m. – 8 p.m. MT.

How the Insured is Notified

If the Insured receives services from an In-Network Provider (Participating), the Provider will provide a statement explaining the cost of the services. If the Insured receives services from an Out-of-Network Provider (Nonparticipating), VSP will provide a statement of costs to the Insured with a reimbursement check.
BLUE CROSS OF IDAHO DISTRICT OFFICE LOCATIONS

For general information, please contact your local Blue Cross of Idaho office:

<table>
<thead>
<tr>
<th>Meridian Office</th>
<th>Lewiston Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross of Idaho</td>
<td>Blue Cross of Idaho</td>
</tr>
<tr>
<td>Customer Service Department</td>
<td>1010 17th Street</td>
</tr>
<tr>
<td>3000 East Pine Avenue</td>
<td>Lewiston, ID 83501</td>
</tr>
<tr>
<td>Meridian, ID 83642</td>
<td></td>
</tr>
<tr>
<td><strong>Mailing Address</strong></td>
<td><strong>Mailing Address</strong></td>
</tr>
<tr>
<td>P.O. Box 7408</td>
<td>P.O. Box 1468</td>
</tr>
<tr>
<td>Boise, ID 83707</td>
<td>Lewiston, ID 83501</td>
</tr>
<tr>
<td>(208) 387-6683 (Boise Area)</td>
<td>(208) 746-0531</td>
</tr>
<tr>
<td>1-800-365-2345</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Coeur d'Alene Office</th>
<th>Pocatello Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross of Idaho</td>
<td>Blue Cross of Idaho</td>
</tr>
<tr>
<td>1450 Northwest Boulevard, Suite 106</td>
<td>275 South 5th Avenue, Suite 150</td>
</tr>
<tr>
<td>Coeur d'Alene, ID 83814</td>
<td>Pocatello, ID 83201</td>
</tr>
<tr>
<td>(208) 666-1495</td>
<td><strong>Mailing Address</strong></td>
</tr>
<tr>
<td></td>
<td>P.O. Box 2578</td>
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<tr>
<td></td>
<td>Pocatello, ID 83206</td>
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<tr>
<td></td>
<td>(208) 232-6206</td>
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<thead>
<tr>
<th>Idaho Falls Office</th>
<th>Twin Falls Office</th>
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<tbody>
<tr>
<td>Blue Cross of Idaho</td>
<td>Blue Cross of Idaho</td>
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<tr>
<td>1910 Channing Way</td>
<td>1431 N. Fillmore St., Suite 200</td>
</tr>
<tr>
<td>Idaho Falls, ID 83404</td>
<td>Twin Falls, ID 83301</td>
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<tr>
<td><strong>Mailing Address</strong></td>
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<tr>
<td>P.O. Box 2287</td>
<td>P.O. Box 5025</td>
</tr>
<tr>
<td>Idaho Falls, ID 83403</td>
<td>Twin Falls, ID 83303</td>
</tr>
<tr>
<td>(208) 522-8813</td>
<td>(208) 733-7258</td>
</tr>
</tbody>
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**IDAHO DEPARTMENT OF INSURANCE CONTACT INFORMATION**

<table>
<thead>
<tr>
<th>Idaho Department of Insurance</th>
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<tbody>
<tr>
<td>Consumer Affairs</td>
</tr>
<tr>
<td>700 W State Street, 3rd Floor</td>
</tr>
<tr>
<td>PO Box 83720</td>
</tr>
<tr>
<td>Boise ID 83720-0043</td>
</tr>
<tr>
<td>1-800-721-3272 or <a href="http://www.DOI.Idaho.gov">www.DOI.Idaho.gov</a></td>
</tr>
</tbody>
</table>
VISION CARE BENEFITS SECTION

This section specifies the benefits an Insured is entitled to receive for the Covered Services described, subject to the other provisions of this Policy.

I. Copayment and Limitations on Frequency of Services
The Copayment amount and limitations on frequency of services are shown in the Benefits Outline.

II. Covered Providers
The following are Covered Providers under this section:
- Optometrist (OD)
- Ophthalmologist (MD)

III. Procedures for Obtaining Covered Services
A. An Insured must contact the Vision Care Services Vendor (VCSV) Participating Provider to make an appointment to receive Covered Services. No preauthorization or special benefit form is required. The doctor will verify eligibility and obtain the necessary authorization from the VCSV.

B. Should the Insured obtain services from a Provider who is not a VCSV Participating Provider, the Insured is responsible for making payment in full to the Provider and will be reimbursed by the VCSV in accordance with the benefits available for Covered Services under this section.

IV. Covered Services
When rendered by a Covered Provider, benefits are provided for the following services:

A. Eye Examination
D. Bifocal Lenses
B. Frame
E. Trifocal Lenses
C. Single Vision Lenses
F. Contact Lenses in place of eyeglasses

A. Eye Examination
A vision examination regardless of its Medical Necessity, including but not limited to, the following services:
(Note: Each test may not be indicated for every patient.)
1. Intermediate Examination—brief or limited routine check-up or vision survey.
2. Vision Analysis—various tests for prescription Lenses.
3. Tonometry—measurement of eye tension for glaucoma.
4. Biomicroscopy—examination of the living eye tissue.
5. Central and/or Peripheral Field Study—measurement of visual acuity in the central and/or peripheral field of vision.
6. Dilation—allows for a better view inside the eye, i.e., optic nerve blood vessels, etc.

B. Prescribed Lenses and Frames
When an eye examination indicates that new Lenses or a new Frame or both are necessary for the proper visual health and welfare of an Insured, they will be supplied, together with such professional services as necessary, which include but are not limited to:
1. Prescribing and ordering proper Lenses.
2. Assisting in the selection of a Frame.
3. Verifying the accuracy of the finished Lenses.
4. Proper fitting and adjustment of the eyeglasses.

The VCSV reserves the right to limit the cost of Frames provided by a Participating Provider. The allowance is published periodically by the VCSV to its Participating Providers and is set at a level to cover the majority of Frames in common use. If an Insured wishes to select a more expensive Frame than allowed in this section, the difference in cost is not the responsibility of the VCSV or Blue Cross of Idaho (BCI).

C. Contact Lenses
1. **Medically Necessary Contact Lenses**—Contact Lenses are furnished when the Participating Provider receives prior approval from the VCSV for any of the following:
   a) Following cataract Surgery.
   b) To correct extreme visual acuity problems that cannot be corrected with eyeglass Lenses.
   c) Certain conditions of Anisometropia.
   d) Keratoconus.

When the Participating Provider receives prior approval for such cases, they are fully covered by the VCSV and are in place of the benefits described for Prescribed Lenses and Frames.

Contact Lenses once furnished as described above can be replaced only upon prior authorization by the VCSV.

2. **Elective Contact Lenses**—if an Insured chooses Contact Lenses from a Participating Provider for reasons other than those mentioned above, benefits are provided as follows: The initial basic examination will be covered in full (as described under Eye Examination) and an allowance will be paid toward a contact lens evaluation fee, fitting costs, and materials in place of the benefits described for Prescribed Lenses and Frames. The allowance amount is shown in the Benefits Outline.

3. For Covered Services rendered by a Provider who is not a Participating Provider, a determination of Medically Necessary versus Elective Contact Lenses will be consistent with Participating Provider services. Reimbursement allowances for Medically Necessary and Elective Contact Lenses include a contact lens evaluation fee, fitting costs, and materials and is in place of all other benefits for materials, including eyeglass Lenses and Frames.

V. **Additional Amount of Payment Provisions**

A. The Insured will pay the Copayment, if any, to the Participating Provider for Covered Services and will pay for any additional services received not covered by this Policy. The VCSV will pay the Participating Provider directly in accordance with the agreement between the VCSV and the Participating Provider.

Subject to the applicable Copayment(s), the VCSV shall pay or otherwise secure the discharge of the cost of Covered Services rendered by a Participating Provider. A Participating Provider shall not make an additional charge to an Insured for amounts in excess of the VCSV’s payment except for Copayments, noncovered services and amounts above the allowance for elective Contact Lenses.

B. If Covered Services are rendered by a Provider who is not a VCSV Participating Provider:
   1. The Insured is responsible for paying the Provider in full. The Insured will be reimbursed in accordance with the benefits available, if any, as shown in the Benefits Outline.
   2. The Nonparticipating Provider is not obligated to accept the VCSV’s payment as payment in full. The VCSV and Blue Cross of Idaho (BCI) are not responsible for the difference, if any, between the VCSV’s payment and the actual charge; any such difference is the Insured’s responsibility.
   3. Benefits for Covered Services are subject to the same time limits and Copayments as those described for Covered Services received from a Participating Provider. Covered Services obtained from a Nonparticipating Provider are in place of obtaining services from a Participating Provider.

C. The amounts shown in the Benefits Outline under Payment for Services Rendered by a Nonparticipating Provider are maximums. The actual amount paid in reimbursement to the Insured is either the amount indicated in the Benefits Outline, the amount actually charged, or the amount usually charged by the Provider of such services to his or her private patients, whichever is less.

VI. **Exclusions and Limitations**

In addition to any other exclusions and limitations of this Policy, the following exclusions and limitations apply to this particular section and throughout the entire Policy, unless otherwise specified:

A. **Enrollee’s Options**
When an Insured selects any of the following options, the VCSV pays the basic cost of the allowed Lenses, and the Insured is responsible for paying the additional costs for the following options:

1. Blended Lenses.
2. Contact Lenses, except as provided in this section.
3. Oversize Lenses.
5. Coating of the lens or Lenses.
6. Laminating of the lens or Lenses.
7. A Frame that costs more than the VCSV’s allowance.
10. UV (ultraviolet) protected Lenses.
11. Polycarbonate Lenses (except for Eligible Dependent Children).
ELIGIBILITY AND ENROLLMENT SECTION

I. Eligibility And Enrollment
All Eligible Employees will have the opportunity to apply for coverage under this Policy. All applications submitted to Blue Cross of Idaho (BCI) by the Group now or in the future, will be for Eligible Employees or Eligible Dependents only.

A. Eligible Employee
Qualifications for eligibility are shown in the Benefits Outline.

B. Eligible Dependent
To qualify as an Eligible Dependent under this Policy, a person must be and remain one (1) of the following:
1. The Enrollee's spouse under a legally valid marriage.
2. The Enrollee’s unmarried natural child, stepchild, legally adopted child, child placed with the Enrollee for adoption, or child for whom the Enrollee or the Enrollee’s spouse has court-appointed guardianship or custody. The child must be:
   a) Under the age of twenty-five (25) and must receive more than one-half (1/2) of his or her financial support from the parent; or
   b) Medically certified as disabled due to mental handicap or retardation or physical handicap and financially dependent upon the Enrollee for support, regardless of age.
3. An Enrollee must notify BCI and/or the Group within thirty (30) days when a dependent no longer qualifies as an Eligible Dependent. Coverage for the former Eligible Dependent will terminate the last day of the month in which the change in eligibility occurred.

II. Leave Of Absence
If the Group maintains regular monthly payments with the regular Group billing, an employer approved temporary leave of absence may continue for a maximum of three (3) months and then cease.

On its regular billing, the Group will notify BCI of the Enrollee's date of departure for the leave of absence, and shall continue its regular contribution for the Enrollee's coverage during the leave of absence.

III. Group Contribution
The Group agrees to pay a specified percentage of the premium for each Eligible Employee, and a specified percentage of the premium for each Eligible Dependent, if applicable. The Enrollee must pay the balance, if any, of the required premium.

IV. Miscellaneous Eligibility And Enrollment Provisions
A. The Group agrees to collect required Enrollee premium payments through payroll withholding and make the required premium payments to BCI on or before the first of each month.

B. Before the effective date of the change, the Group shall submit all eligibility changes for Enrollees and Eligible Dependents on BCI's usual forms. It is the Group's responsibility to verify that all Insureds are eligible for coverage as specified in this Policy. BCI shall have the right to audit the Group's employment, payroll, and eligibility records to ensure that all Insureds are eligible and properly enrolled and to ensure that the Group meets enrollment requirements.

C. This Policy is issued to the Group upon the express condition that a pre-established required percentage of the Eligible Employees specified in the Application for Group Coverage who meet the underwriting criteria of BCI are and continue to be Enrollees. This Policy is issued upon the express condition that the Group continues to make the employer contribution specified in the Application for Group Coverage and this Policy. BCI may terminate this Policy if the percentage of Eligible Employees as Enrollees or the percentage of the employer contribution drops below the required level.
D. 1. For an Eligible Employee to enroll himself or herself and any Eligible Dependents for coverage under this Policy (or for an Enrollee to enroll Eligible Dependents for coverage) the Eligible Employee or Enrollee, as the case may be, must complete a BCI application and submit it and any required premiums to BCI.

2. Except as provided otherwise in this section, the Effective Date of coverage for an Eligible Employee or an Eligible Dependent will be the first day of the month following the month of enrollment.

3. New faculty members are effective the first of the month in which they are hired. Newly hired administrators and other year-round employees are effective the 1st of the month following the date of hire.

4. The Effective Date of coverage for an Eligible Employee and any Eligible Dependents listed on the Eligible Employee’s application is the Group's Policy Date if the application is submitted to BCI by the Group on or before the Policy Date.

E. 1. Except as stated otherwise in subparagraphs E2. and E3. below, the initial enrollment period is thirty (30) days for Eligible Employees and Eligible Dependents. The initial enrollment period begins on the date the Eligible Employee or Eligible Dependent first becomes eligible for coverage under this Policy.

2. An Enrollee’s newborn Dependent, including adopted newborn children who are placed with the adoptive Enrollee within sixty (60) days of the adopted child’s date of birth, are covered under this Policy from and after the date of birth for 60 days.

In order to continue coverage beyond the sixty (60) days outlined above, the Enrollee must complete an enrollment application and submit the required premium within thirty-one (31) days of the date monthly billing is received by the Group and a notice of premium is provided to the Enrollee by the Group.

When a newborn child is added and the monthly premium changes, a full month's premium is required for the child if his or her date of birth falls on the 1st through the 15th day of the month. No premium for the first month is required if the child's date of birth falls on the 16th through the last day of the month.

The Effective Date of coverage will be the date of birth for a newborn natural child or a newborn child adopted or placed for adoption within sixty (60) days of the child’s date of birth.

If the date of adoption or the date of placement for adoption of a child is more than sixty (60) days after the child’s date of birth, the Effective Date of coverage will be the date of adoption or the date of placement for adoption. In this Policy, ‘child’ means an individual who has not attained age eighteen (18) years as of the date of the adoption or placement for adoption. In this Policy, “placed for adoption” means physical placement in the care of the adoptive Enrollee, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it means when the adoptive Enrollee signs an agreement for adoption of the child and signs an agreement assuming financial responsibility for the child.

3. The initial enrollment period is sixty (60) days for an Eligible Dependent who becomes eligible because of marriage. The initial enrollment period begins on the date of such marriage. The Effective Date of coverage is the first day of the month following the month of enrollment.

F. Late Enrollee

If an Eligible Employee or an Eligible Dependent does not enroll during the applicable initial enrollment period described in Paragraph E. of this section, the Eligible Employee or Eligible
Dependent is a Late Enrollee. Following the receipt and acceptance of a completed enrollment application, the Effective Date of coverage for a Late Enrollee will be the date of the Group’s next Policy Date.

V. Qualified Medical Child Support Order

A. If this Policy provides for family coverage, BCI will comply with a Qualified Medical Child Support Order (QMCSO) according to the provisions of Section 609 of ERISA and any other applicable federal or state laws. A medical child support order is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that:
   1. Provides for child support with respect to a child of an Enrollee or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law) and relates to benefits under this Policy, or
   2. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to a group health plan.

B. A medical child support order meets the requirements of a QMCSO if such order clearly specifies:
   1. The name and the last known mailing address (if any) of the Enrollee and the name and mailing address of each child covered by the order.
   2. A reasonable description of the type of coverage to be provided by this Policy to each such child, or the manner in which such type of coverage is to be determined.
   3. The period to which such order applies.

C. 1. Within fifteen (15) days of receipt of a medical child support order, BCI will notify the party who sent the order and each affected child of the receipt and of the criteria by which BCI determines if the medical child support order is a QMCSO. In addition, BCI will send an application to each affected child. The application must be completed by or on behalf of the affected child and promptly returned to BCI. With respect to a medical child support order, affected children may designate a representative for receipt of copies of notices sent to each of them.
   2. Within thirty (30) days after receipt of a medical child support order and a completed application, BCI will determine if the medical child support order is a QMCSO and will notify the Enrollee, the party who sent the order, and each affected child of such determination.

D. BCI will make benefit payments to the respective party for reimbursement of eligible expenses paid by an enrolled affected child or by an enrolled affected child's custodial parent, legal guardian, or the Idaho Department of Health and Welfare.
DEFINITIONS SECTION

For reference, most terms defined in this section are capitalized throughout this Policy. Other terms may be defined where they appear in this Policy. All Providers listed in this Policy and in the following section must be licensed and/or registered by the state where the services are rendered, unless exempt by federal law, and must be performing within the scope of license in order for the VCSV to provide benefits. Definitions in this Policy shall control over any other definition or interpretation unless the context clearly indicates otherwise.

Accidental Injury—an objectively demonstrable impairment of bodily function or damage to part of the body caused by trauma from a sudden, unforeseen external force or object, occurring at a reasonably identifiable time and place, and without an Insured’s foresight or expectation, which requires medical attention at the time of the accident. The force may be the result of the injured party’s actions, but must not be intentionally self-inflicted unless caused by a medical condition or domestic violence. Contact with an external object must be unexpected and unintentional, or the results of force must be unexpected and sudden.

Adverse Benefit Determination—any denial, reduction or termination of, or the failure to provide payment for, a benefit for services or ongoing treatment under this Policy.

Anisometropia—a condition of unequal refractive state for the two (2) eyes, one (1) eye requiring a different lens correction than the other.

Benefit Period—the specified period of time in which an Insured’s benefits for incurred Covered Services accumulate toward annual benefit limits and Out-of-pocket Limits.

Blended Lenses—bifocals that do not have a visible dividing line.

Blue Cross of Idaho Health Service, Inc. (Blue Cross of Idaho or BCI)—a nonprofit mutual insurance company.

Coated Lenses—a substance added to a finished lens on one (1) or both surfaces

Coinsurance—the percentage of the Maximum Allowance or the actual charge, whichever is less, an Insured is responsible to pay Out-of-pocket for Covered Services after satisfaction of any applicable Copayments.

Contact Lenses—ophthalmic corrective Lenses (either glass or plastic, ground or molded). They must be prescribed by an Optometrist or Ophthalmologist to be directly fitted to the Insured’s eye.

Cost Effective—A requested or provided medical service or supply that is Medically Necessary in order to identify or treat an Insured’s health condition, illness or injury and that is:

1. Provided in the most cost-appropriate setting consistent with the Insured’s clinical condition and the Covered Provider’s expertise. For example, when applied to services that can be provided in either an Inpatient hospital setting or Outpatient hospital setting, the Cost Effective setting will generally be the outpatient setting. When applied to services that can be provided in a hospital setting or in a physician office setting, the Cost Effective setting will generally be the physician office setting.

2. Not more costly than an alternative service or supply, including no treatment, and at least as likely to produce an equivalent result for the Insured’s condition, Disease, Illness or injury.

Copayment—a designated dollar and/or percentage amount, separate from Coinsurance, that an Insured is financially responsible for and must pay to a Provider at the time certain Covered Services are rendered.

Covered Provider—a Provider specified in this Policy from whom an Insured must receive Covered Services in order to be eligible to receive benefits.

Covered Service—when rendered by a Covered Provider, a service, supply, or procedure specified in this Policy for which benefits will be provided to an Insured.
**Disease**—any alteration in the body or any of its organs or parts that interrupts or disturbs the performance of vital functions, thereby causing or threatening pain, weakness, or dysfunction. A Disease can exist with or without an Insured’s awareness of it, and can be of known or unknown cause(s).

**Effective Date**—the date when coverage for an Insured begins under this Policy.

**Eligible Dependent**—a person eligible for enrollment under an Enrollee’s coverage.

**Eligible Employee**—an employee, sole proprietor or partner of a Group who is entitled to apply as an Enrollee.

**Enrollee**—an Eligible Employee who has enrolled for coverage and has satisfied the requirements of the Eligibility and Enrollment Section.

**Enrollment Date**—the date of enrollment of an Eligible Employee or Eligible Dependent under this Policy, or if earlier, the first day of the probationary period for such enrollment.

**Family Coverage**—the enrollment of an Enrollee and two (2) or more Eligible Dependents under this Policy.

**Frame**—a standard eyeglass Frame adequate to hold Lenses.

**Group**—a sole proprietorship, partnership, association, corporation, or other entity that has applied for Group coverage and has agreed to comply with all the terms and requirements of this Policy.

**Illness**—a deviation from the healthy and normal condition of any bodily function or tissue. An Illness can exist with or without an Insured’s awareness of it, and can be of known or unknown cause(s).

**In-Network Services**—Covered Services provided by a Participating Provider.

**Insured**—an Enrollee or an enrolled Eligible Dependent covered under this Policy.

**Investigational**—any technology (service, supply, procedure, treatment, drug, device, facility, equipment or biological product), which is in a developmental stage or has not been proven to improve health outcomes such as length of life, quality of life, and functional ability. A technology is considered investigational if, as determined by the VCSV, it fails to meet any one of the following criteria:

- The technology must have final approval from the appropriate government regulatory body. This applies to drugs, biological products, devices, and other products/procedures that must have approval from the U.S. Food and Drug Administration (FDA) or another federal authority before they can be marketed. Interim approval is not sufficient. The condition for which the technology is approved must be the same as that BCI is evaluating.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of current published medical literature and investigations published in peer-reviewed journals. The quality of the studies and consistency of results will be considered. The evidence should demonstrate that the technology can measure or alter physiological changes related to a Disease, injury, Illness, or condition. In addition, there should be evidence that such measurement or alteration affects health outcomes.
- The technology must improve the net health outcome. The technology’s beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
- The technology must be as beneficial as any established alternatives.
- The technology must show improvement that is attainable outside the investigational setting. Improvements must be demonstrated when used under the usual conditions of medical practice.

If a technology is determined to be investigational, all services specifically associated with the technology, including but not limited to associated procedures, treatments, supplies, devices, equipment, facilities or drugs will also be considered investigational.

**Keratoconus**—a developmental or dystrophic deformity of the cornea in which it becomes cone-shaped due to a thinning and stretching of the tissue in its central area.
Large Employer—any person, firm, corporation, partnership or association that is actively engaged in business that, on at least 50% of its working days during the preceding calendar year, employed no less than fifty-one (51) Eligible Employees, the majority of whom were employed within Idaho. In determining the number of Eligible Employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one (1) employer.

Lenses—ophthalmic corrective Lenses (either glass or plastic, ground or molded). They must be prescribed by an Optometrist or Ophthalmologist to improve visual acuity or performance and to be fitted to a Frame. Amounts payable are based on a lens blank not more than sixty-one (61) millimeters in diameter, tinted no darker than the equivalent of Pink #1 or #2 and without photosensitive or anti-reflective properties.

Maximum Allowance—for Covered Services under the terms of this Policy, Maximum Allowance is the lesser of the billed charge or the amount established as the highest level of compensation for a Covered Service as established by the VCSV.

Medically Necessary (or Medical Necessity)—The Covered Service or supply recommended by the treating Covered Provider to identify or treat an Insured’s condition, Disease, Illness or Accidental Injury and which is determined by BCI to be:

1. The most appropriate supply or level of service, considering potential benefit and harm to the Insured.
2. Proven to be effective in improving health outcomes;
   a. For new treatment, effectiveness is determined by peer reviewed scientific evidence;
   b. For existing treatment, effectiveness is determined first by peer reviewed scientific evidence, then by professional standards, then by expert opinion.
3. Not primarily for the convenience of the Insured or Covered Provider.
4. Cost Effective for this condition.

The fact that a Covered Provider may prescribe, order, recommend, or approve a service or supply does not, in and of itself, necessarily establish that such service or supply is Medically Necessary under this Policy.

The term Medically Necessary as defined and used in this Policy is strictly limited to the application and interpretation of this Policy, and any determination of whether a service is Medically Necessary hereunder is made solely for the purpose of determining whether services rendered are Covered Services.

Nonparticipating Provider—a Provider that has not entered into a written agreement with the VCSV regarding payment for Covered Services rendered to an Insured under this policy.

Ophthalmologist—a doctor of medicine (M.D.) who is both a medical doctor and a surgeon. The ophthalmologist is licensed to exam, diagnose and treat disorders and diseases of the eye and visual system of the brain, as well as prescribe corrective lenses (glasses or contacts).

Optometrist—a person who is licensed and specializes in optometry to examine, measure and treat certain visual defects by means of corrective lenses or other methods that do not require a license as a physician.

Orthoptics—the teaching and training process for improvement of visual perception and coordination of the two (2) eyes for efficient and comfortable binocular vision.

Out-of-Network Services—any Covered Services rendered by a Nonparticipating Provider.

Out-of-Pocket Limit—the amount of Out-of-pocket expenses incurred during one (1) Benefit Period that an Insured is responsible for paying. Eligible Out-of-pocket expenses include only the Insured’s Coinsurance for eligible Covered Services.

Outpatient—an Insured who receives services or supplies while not an inpatient.

Physician—a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) licensed to practice medicine.
Policy—this Policy, which includes only the Benefits Outline, Group application, individual enrollment applications, Insured identification cards, any written endorsements, riders, amendments, or any other written agreements between BCI and the Group executed by an authorized officer of BCI.

Policy Date—the date specified in this Policy when coverage commences for the Group.

Post-Service Claim—any claim for a benefit under this Policy that does not require prior authorization before services are rendered.

Pre-Service Claim—any claim for a benefit under this Policy that requires prior authorization before services are rendered.

Provider—a person or entity that is licensed, where required, to render Covered Services. For the purposes of this Policy, Providers include only Ophthalmologists and Optometrists.

Single Coverage—the enrollment of only the Enrollee under this Policy.

Surgery—within the scope of a Provider’s license, the performance of:
1. Generally accepted operative and cutting procedures.
2. Invasive procedures using specialized instruments.
3. Customary preoperative and postoperative care.

Tinted Lenses—Lenses that have an additional substance added to produce constant tint.

Totally Disabled (or Total Disability)—as certified in writing by an attending Physician, a condition resulting from Disease, Illness or Accidental Injury causing:
1. An Enrollee’s inability to perform the principal duties of the regular employment or occupation for which the Enrollee is or becomes qualified through education, training, or experience; and the Enrollee is not in fact engaged in any work profession, or avocation for fees, gain, or profit; or
2. An enrolled Eligible Dependent to be so disabled and impaired as to be unable to engage in the normal activities of an individual of the same age and gender.

Two-Party Coverage—the enrollment of the Enrollee and one (1) Eligible Dependent under this Policy.

Vision Care Services Vendor (VCSV)—an entity contracting with BCI to provide Vision Care Services to its Insureds.
EXCLUSIONS AND LIMITATIONS SECTION

The following exclusions and limitations apply to the entire Policy, unless otherwise specifically listed as a Covered Service in this Policy.

I. General Exclusions and Limitations

There are no benefits for services, supplies, drugs or other charges that are:

A. Not Medically Necessary.

B. In excess of the Maximum Allowance.

C. Not prescribed by or upon the direction of a Physician or other professional Provider; or which are furnished by any individuals or facilities other than Physicians, and other Providers.

D. Investigational in nature.

E. Provided for any condition, Disease, Illness or Accidental Injury to the extent that the Insured is entitled to benefits under occupational coverage, obtained or provided by or through the employer under state or federal Workers' Compensation Acts or under Employer Liability Acts or other laws providing compensation for work-related injuries or conditions. This exclusion applies whether or not the Insured claims such benefits or compensation or recovers losses from a third party.

F. Provided or paid for by any federal governmental entity or unit except when payment under this Policy is expressly required by federal law, or provided or paid for by any state or local governmental entity or unit where its charges therefore would vary, or are or would be affected by the existence of coverage under this Policy.

G. Provided for any condition, Accidental Injury, Disease or Illness suffered as a result of any act of war or any war, declared or undeclared.

H. Furnished by a Provider who is related to the Insured by blood or marriage and who ordinarily dwells in the Insured's household.

I. Received from a vision, or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.

J. Rendered prior to the Insured's Effective Date

K. For telephone consultations, and all computer or Internet communications; for failure to keep a scheduled visit or appointment; for completion of a claim form; or for personal mileage, transportation, food or lodging expenses or for mileage, transportation, food or lodging expenses billed by a Physician or other Professional Provider.

L. For the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation, unless such injuries are a result of a medical condition or domestic violence.

M. For treatment or other health care of any Insured in connection with an Illness, Disease, Accidental Injury or other condition which would otherwise entitle the Insured to Covered Services under this Policy, if and to the extent those benefits are payable to or due the Insured under any medical payments provision, no fault provision, uninsured motorist provision, underinsured motorist provision, or other first party or no fault provision of any automobile, homeowner's, or other similar policy of insurance, contract, or underwriting plan.

In the event Blue Cross of Idaho (BCI) for any reason makes payment for or otherwise provides benefits excluded by the above provisions, it shall succeed to the rights of payment or reimbursement of the compensated Provider, the Insured, and the Insured's heirs and personal representative against
all insurers, underwriters, self-insurers or other such obligors contractually liable or obliged to the
Insured, or his or her estate for such services, supplies, drugs or other charges so provided by BCI in
connection with such Illness, Disease, Accidental Injury or other condition.

N. Any services or supplies for which an Insured would have no legal obligation to pay in the absence of
coverage under this Policy or any similar coverage; or for which no charge or a different charge is
usually made in the absence of insurance coverage.

O. Provided to a person enrolled as an Eligible Dependent, but who no longer qualifies as an Eligible
Dependent due to a change in eligibility status that occurred after enrollment.

P. Provided outside the United States, which if had been provided in the United States, would not be a
Covered Service under this Policy.

Q. Furnished by a Provider or caregiver that is not listed as a Covered Provider.

R. For the purchase of Therapy or Service Dogs/Animals and the cost of training/maintaining said
animals.

S. Orthoptics or other vision training and any associated supplemental testing.

T. Plano Lenses.

U. Two (2) pair of eyeglasses in place of bifocals.

V. Replacement of Lenses, Frames or Contact Lenses furnished hereunder that are lost or broken
(Lenses, Frames or Contact Lenses are only replaced at the normal intervals when Covered Services
are otherwise available).

W. Medical or surgical treatment of the eye(s).

X. Any eye examination or any corrective eyewear required by an employer as a condition of
employment.

Y. Low vision aids.

Z. Solutions and/or cleaning products for eyeglasses or Contact Lenses.

II. Preexisting Condition Waiting Period
There are no waiting periods for treatment of preexisting conditions under this Policy.
GENERAL PROVISIONS SECTION

I. Entire Policy—Changes
This Policy, which includes only the Benefits Outline, Group application, individual enrollment applications, Insured identification cards, and any written endorsements, riders, amendments or other written agreements approved in writing by an authorized Blue Cross of Idaho (BCI) officer, is the entire Policy between the Group and BCI. No agent or representative of BCI, other than a BCI officer, may change this Policy or waive any of its provisions. This Policy supplants and replaces any and all previous oral or written agreements, certificates, contracts, policies or representations, which shall have no further force and effect.

II. Records of Insured Eligibility and Changes in Insured Eligibility
A. The Group shall furnish all data required by BCI for it to provide coverage of the Group's Insureds under this Policy. In addition, the Group shall provide written notification to BCI within thirty (30) days of the effective date of any changes in an Insured's enrollment and benefit coverage status under this Policy.

B. A notification by the Group to BCI must be furnished on BCI approved forms, and according to rules and regulations of BCI. The notification must include all information reasonably required by BCI to effect changes, and must be accompanied by payment of applicable premiums.

III. Termination or Modification of This Policy
A. Pursuant to the provisions of this Subsection III., the Group or BCI may unilaterally terminate this Policy. BCI may unilaterally modify the terms of this Policy, including but not limited to, benefits, premiums, and other provisions. Unless specified otherwise in this Policy, such termination or modification may be accomplished by giving written notice to the other party at least forty (40) days in advance of the effective date of the termination or modification. Except for modifications resulting from statutory and/or regulatory changes affecting benefits, BCI may modify benefits only at the time of the Group’s annual renewal of coverage.

If there is a modification and its effective date is not January 1 or the Groups renewal date, all amounts previously credited to an Insured’s benefit limit during the Benefit Period in which the modification is made shall be credited against the Insured’s benefit limit under this Policy as modified for the remainder of that Benefit Period.

However, this provision does not obligate BCI to provide benefits beyond the term of this Policy. The Group agrees that it will notify Insureds of any changes in benefits, or premiums, at least thirty (30) days prior to the effective date of such modifications. The Group's subsequent payment of premiums shall constitute conclusive documentation that the Group and its Insureds have accepted and agreed to any such modification(s).

B. This Policy may be unilaterally terminated by BCI for any of the following:
1. For the Group's nonpayment of the appropriate premiums when due. A payer financial institution's return of or refusal to honor a check or draft constitutes nonpayment of premiums.
2. For the Group's fraud or intentional misrepresentation of a material fact.
3. For the Group's failure to maintain the enrollment percentage specified in the Application for Group Coverage. BCI may randomly audit enrollment to insure compliance. Failure to provide information requested in the audit may also result in termination.
4. For the Group's failure to make the employer contribution specified in the Application for Group Coverage.
5. If the Group no longer qualifies as a Large Employer under this Policy.
6. In the case where this Policy is available to the Group only through an association as defined in Idaho Code § 41-2202, the membership of the Group in the association (on the basis of which the coverage of this Policy is provided) ceases but only if the coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any Insured.
C. If the Group fails to pay premiums as agreed in the Eligibility and Enrollment Section, this Policy will terminate without notice at the end of the period for which the last premiums were paid. This Policy does not have a grace period; however, if the Group makes payment of the premiums within thirty (30) days after the due date, BCI will reinstate this Policy as of the due date. No benefits are available during this thirty (30)-day period unless all premiums are properly paid before expiration of the thirty (30)-day period. BCI reserves the right to apply a twelve percent (12%) annualized interest fee on any portion of the balance owed by the Group to BCI that remains unpaid thirty (30) days or more beyond the original due date.

IV. Termination or Modification of an Insured's Coverage Under This Policy
A. If an Enrollee ceases to be an Eligible Employee or the Group does not remit the required premium, the Enrollee's coverage and the coverage of any and all enrolled Eligible Dependents will terminate on the last day of the last month for which payment was made.

B. Except as provided in this paragraph, coverage under this Policy will terminate on the date an Insured no longer qualifies as an Insured, as defined in the Eligibility and Enrollment Section. Coverage will not terminate because of age for an Insured who is an unmarried dependent child incapable of self-sustaining employment by reason of mental handicap or retardation or physical handicap, who became so incapable prior to reaching the age limit, and who is chiefly dependent on the Enrollee for support and maintenance, provided the Enrollee, within thirty-one (31) days of when the dependent child reaches the age limit, has submitted to BCI (at the Enrollee's expense) a Physician's certification of such dependent child's incapacity. BCI may require, at reasonable intervals during the (2) two years following when the child reaches the age limit, subsequent proof of the child's continuing disability and dependency. After (2) two years, BCI may require such subsequent proof once each year. Coverage for the dependent child will continue so long as this Policy remains in effect, the child's disability and financial dependency exists, and the child has not exhausted benefits.

C. Termination or modification of this Policy automatically terminates or modifies all of the Insureds' coverage and rights hereunder. It is the responsibility of the Group to notify all of its Insureds of the termination or any modification of this Policy, and BCI's notice thereof to the Group, upon mailing or any other delivery, shall constitute complete and conclusive notice to the Insureds.

D. Except as otherwise provided in this Policy, no benefits are available to an Insured for Covered Services rendered after the date of termination of an Insured's coverage.

E. If BCI discovers that an Insured has made any misrepresentation, omission, or concealment of fact in obtaining coverage under this Policy which was or would have been material to BCI’s acceptance of a risk, extension of coverage, provision of benefits or payment of any claim, BCI may take action against the Group, including but not limited to, increasing the Group’s premiums.

F. Prior to legal finalization of an adoption, the coverage provided in this Policy for a child placed for adoption with an Enrollee continues as it would for a naturally born child of the Enrollee until the first of the following events occurs:

1. The date the child is removed permanently from placement and the legal obligation terminates, or
2. The date the Enrollee rescinds, in writing, the agreement of adoption or the agreement assuming financial responsibility.

If one (1) of the foregoing events occurs, coverage shall terminate on the last day of the calendar month in which such event occurs.

G. Coverage under this Policy will terminate for an Eligible Dependent on the last day of the month the Eligible Dependent no longer qualifies as an Eligible Dependent due to a change in eligibility status.

V. Benefits After Termination of Coverage
A. When this Policy remains in effect but an Insured's coverage terminates for reasons other than those specified in General Provision IV.E., benefits will be continued:
1. If the Insured is eligible for and properly elects continuation coverage in accordance with the applicable provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any amendments thereto.

Most employers who employ twenty (20) or more people on a typical business day are subject to COBRA. If the Group is subject to COBRA, an Insured may be entitled to continuation coverage. Insureds should check with the Group for details.

B. When the Group or BCI terminates this Policy, benefits will be continued:
   1. For Covered Services directly related to a Total Disability that existed on the date of termination, in accordance with state law and regulations. Such Covered Services are subject to all the terms, limitations, and provisions of this Policy and will be provided for no more than twelve (12) consecutive months following the date coverage terminates or until the Total Disability ceases, whichever occurs first.

VI. Contract Between BCI and the Group—Description of Coverage
This policy is a contract between BCI and the Group. BCI will provide the Group with copies of the Policy to give to each Enrollee as a description of coverage, but this Policy shall not be construed as a contract between BCI and any Enrollee. BCI’s mailing or other delivery of copies of this Policy to the Group constitutes complete and conclusive issuance and delivery thereof to each Enrollee.

VII. Applicable Law
This Policy shall be governed by and interpreted according to the laws of the state of Idaho.

VIII. Notice
Any notice required under this Policy must be in writing. BCI’s notices to the Group will be sent to the Group's address as it appears on BCI’s records, and mailing or other delivery to the Group constitutes complete and conclusive notice to the Insureds. Notice given to BCI must be sent to BCI's address contained in the Group Application. The Group shall give BCI immediate written notice of any change of address for the Group or any of its Insureds. BCI shall give the Group immediate written notice of any change in BCI’s address. When BCI is required to give advice or notice, the depositing of such advice or notice with the U.S. Postal Service, regular mail, or the other delivery conclusively constitutes the giving of such advice or notice on the date of such mailing or delivery.

IX. Benefits to Which Insureds are Entitled
A. Subject to all of the terms of this Policy, an Insured is entitled to benefits for Covered Services in the amounts specified in the benefit sections and/or in the Benefits Outline.

B. Benefits will be provided only if Covered Services are prescribed by, or performed by, or under the direction of a Physician or other Professional Provider.

C. Benefits for Covered Services specified in this Policy will be provided only for Covered Services that are rendered by the Covered Providers specified in the benefits sections of this Policy and that are regularly and customarily included in such Covered Providers' charges.

D. Covered Services are subject to the availability of Facility Providers and the ability of the employees of such Providers and of available Physicians to provide such services. BCI shall not assume nor have any liability for conditions beyond its control which affect the Insured's ability to obtain Covered Services.

X. Notice of Claim
BCI is not liable under this Policy to provide benefits unless a proper claim is furnished to BCI that shows Covered Services have been rendered to an Insured. A claim must be submitted within one (1) year from the date a Covered Service is rendered. The claim must include all the data necessary for BCI to determine benefits.

XI. Release and Disclosure of Medical Records and Other Information
A. In order to effectively apply the provisions of this Policy, BCI may obtain information from Providers and other entities pertaining to any health related services that the Insured may receive or may have received in the past. BCI may also disclose to Providers and other entities, information obtained from the Insured’s transactions such as policy coverage, premiums, payment history and claims data necessary to allow the processing of a claim and for other health care operations. To protect the Insured’s privacy, BCI treats all information in a confidential manner. For further information regarding BCI’s privacy policies and procedures, the Insured may request a copy of BCI’s Notice of Privacy Practices by contacting customer service at the number provided in this Policy.

B. As a condition of coverage under this Policy, each Insured authorizes Providers to testify at BCI's request as to any information regarding the Insured's medical history, services rendered, and treatment received. Any and all provisions of law or professional ethics forbidding such disclosures or testimony are waived by and in behalf of each Insured.

XII. Exclusion of General Damages
Liability under this Policy for benefits conferred hereunder, including recovery under any claim or breach of this Policy, is limited to the actual benefits for Covered Services as provided herein and shall specifically exclude any claim for general damages, including but not limited to, alleged pain, suffering or mental anguish, or for economic loss, or consequential loss or damages.

XIII. Payment of Benefits
A. The Insured authorizes BCI to make payments directly to Providers rendering Covered Services to the Insured for benefits provided under this Policy. Notwithstanding this authorization, BCI reserves and shall have the right to make such payments directly to the Insured. Except as provided by law, BCI's right to pay an Insured directly is not assignable by an Insured nor can it be waived without BCI's concurrence, nor may the right to receive benefits for Covered Services under this Policy be transferred or assigned, either before or after Covered Services are rendered.

B. Once Covered Services are rendered by a Provider, BCI is not obliged to honor Insured requests not to pay claims submitted by such Provider, and BCI shall have no liability to any person because of its rejection of such request. However, for good cause and in its sole discretion, BCI may nonetheless deny all or any part of any Provider claim.

XIV. Insured/Provider Relationship
A. The choice of a Provider is solely the Insured's.

B. BCI does not render Covered Services but only makes payment for Covered Services received by Insureds. BCI is not liable for any act or omission or for the level of competence of any Provider, and BCI has no responsibility for a Provider's failure or refusal to render Covered Services to an Insured.

C. The use or nonuse of an adjective such as Participating or Nonparticipating is not a statement as to the ability of the Provider.

XV. Participating Plan
BCI may, in its sole discretion, make an agreement with any appropriate entity (referred to as a Participating Plan) to provide, in whole or in part, benefits for Covered Services to Insureds, but it shall have no obligation to do so.

XVI. Benefits For Medicare Eligible’s Who are Covered Under This Policy
A. If the Group has twenty (20) or more employees, any Eligible Employee or spouse of an Eligible Employee who becomes or remains an Insured of the Group covered by this Policy after becoming eligible for Medicare (due to reaching age sixty-five (65)) is entitled to receive the benefits of this Policy as primary.

B. If the Group has one hundred (100) or more employees or the Group is an organization which includes an employer with one hundred (100) or more employees, any Eligible Employee, spouse of an Eligible Employee or dependent child of an Eligible Employee who becomes or remains an Insured...
of the Group covered by this Policy after becoming eligible for Medicare due to disability is entitled
to receive the benefits of this Policy as primary.

C. An Insured eligible for Medicare based solely on end stage renal disease is entitled to receive the
benefits of this Policy as primary for eighteen (18) months only, beginning with the month of
Medicare entitlement, if Medicare entitlement is effective before March 1, 1996. If Medicare
entitlement is effective on or after March 1, 1996, the Insured is entitled to receive benefits of this
Policy as primary for thirty (30) months only, beginning with the month of Medicare entitlement.

D. The Group's retirees, if covered under this Policy, and Eligible Employees or spouses of Eligible
Employees who are not subject to paragraphs A., B. or C. of this provision and who are Medicare
eligible, will receive the benefits of this Policy reduced by any benefits available under Medicare.
This applies even if the Insured fails to enroll in Medicare or does not claim the benefits available
under Medicare.

XVII. Indemnity by the Group and Blue Cross of Idaho
The Group and BCI agree to defend, indemnify, and hold the other party harmless from and against any claim,
demand, expense, loss, damage, cost, judgment, fee, or liability the other party may receive, incur, or sustain
that is caused by or arises by reason of any misstatement, misrepresentation, oversight, error, omission, delay,
or mistake in providing the other party or any Insured notice or advice of any relevant fact, event, or matter
pertinent to claims, benefits, or coverage under this Policy.

XXVIII. Incorporated by Reference
All of the terms, limitations and exclusions of coverage contained in this Policy are incorporated by reference
into all sections, endorsements, riders, and amendments and are as effective as if fully expressed in each one
unless specifically noted to the contrary.

XIX. Inquiry and Appeals Procedures
A. Scope/Policy
The Vision Care Services Vendor (VCSV) Insured Claim/Authorization Appeal Policy and Procedure
is designed to allow the VCSV Insured and/or their representative the opportunity for a full and fair
review of a previously denied authorization or claim.

1. Definitions
   
   Appeal: A request for reconsideration of whole or partial denial of services, care or
treatment, which an Insured believes, meets the guidelines for authorization and/or payment.

   Appeal categories include:
   a) Expedited Appeal: An expedited appeal must be communicated orally or in writing
      and will be processed within ten (10) business days of receipt of the request. The
      appeal is for services or procedures that, if delayed, could seriously jeopardize the
      health of the Insured or create a financial hardship.
   b) Standard Appeal: Must be in writing and will be processed within sixty (60) days of
      receipt of request.

   2. Instructions for requesting an appeal are included in each denial notification letter and all
      Explanation of Benefits that are sent to the Insured.

   3. Appeals must be filed within sixty (60) days of the date of a written notification.

   4. The Insured, and/or Insured’s representative may request an appeal. When an Insured and/or
      Insured’s representative requests an expedited appeal, the VCSV staff will determine if the
      expedited process will be initiated.

   5. Written appeals are reviewed by the Satisfaction Opportunity Unit. The appeal is delegated
to a staff member who was not involved in the initial determination.

The VCSV may refer the Insured back to his/her Group to participate in the Group’s appeal process.

B. Procedure
1. Expedited Appeals
a) An appeal may be requested by telephone, fax, e-mail or in writing. Oral requests will be documented by the VCSV staff.
b) Satisfaction Opportunity Unit staff will coordinate all written appeals from the Insured and/or their representative. The appeal will be acknowledged in writing within five (5) business days of receipt.
c) If an Insured, with provider support, requests an expedited appeal, the VCSV staff will grant the request if the standard sixty (60) day appeal process could seriously jeopardize the health of the Insured or create a financial hardship.
d) The Insured has the right to review any documents pertinent to the denial and to submit issues and comments in writing to the Satisfaction Opportunity Unit for consideration in the appeal.
e) The VCSV staff will complete the review within ten (10) business days of receipt of the information. The appeal determination and rationale is documented in the Research Inquiry System and routed to the Satisfaction Opportunity Unit for processing.
f) The VCSV staff will communicate the determination via telephone to the Insured on the day of the determination. The VCSV staff will then send a notification letter, within one (1) business day, to the Insured and any other applicable parties, confirming the determination. The written decision shall include the specific reasons for the decision, as well as specific references to the pertinent plan or policy provisions on which the decision is based. If the denial is upheld, instructions for requesting further appeals will be communicated. The VCSV will follow the Rules of the American Arbitration Association if applicable.

C. Standard Appeal
1. The appeal must be made in writing by the Insured and/or their representative.
2. The Insured has the right to review any documents pertinent to the denial, and to submit issues and comments in writing to the Satisfaction Opportunity Unit for consideration in the appeal.
3. The Satisfaction Opportunity Unit staff will process the appeal. The appeal will be acknowledged in writing within five (5) business days of receipt. Additional documentation or information may be requested as necessary to support the appeal. If requested information is not received, the appeal will be reviewed based on available information.
4. Special circumstances may require an extension of time for review, but not later than one hundred twenty (120) days after the receipt of the appeal. In such cases, a written notice will be communicated to the Insured prior to the beginning of the extension.
5. Standard appeals will be completed within sixty (60) days of receipt of all necessary information. The Satisfaction Opportunity Unit will communicate in writing to the Insured, the Insured’s representative and any other applicable parties as required by the Insured’s Group, within one (1) business day of the determination. The written decision shall include the specific reasons for the decision, as well as specific references to the pertinent plan or policy provisions on which the decision is based. If the denial is upheld, instructions for requesting further appeals will be included.

XX. Plan Administrator—COBRA and ERISA
BCI is not the plan administrator for compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) and any amendments to it; nor is BCI the plan administrator for the Employee Retirement Income Security Act (ERISA) and any amendments to it.

Except for services BCI has agreed to perform regarding COBRA, the Group is responsible for satisfaction of notice, disclosure, and other obligations if these laws are applicable to the Group.

XXI. Reimbursement of Benefits Paid by Mistake
If BCI mistakenly pays benefits on behalf of an Enrollee or his or her Eligible Dependent(s) that the Enrollee or his or her Eligible Dependent(s) is not entitled to under this Policy, the Enrollee must reimburse the erroneous benefits to BCI.
The reimbursement is due and payable as soon as BCI notifies the Enrollee and requests reimbursement. BCI may also recover such erroneous benefits from any other person or Provider to whom the payments were made. If reimbursement is not made in a timely manner, BCI may reduce benefits or reduce an allowance for benefits as a set-off toward reimbursement.

Even though BCI may elect to continue to provide benefits after mistakenly paying benefits, BCI may still enforce this provision. This provision is in addition to, not instead of, any other remedy BCI may have at law or in equity.

XXII. Subrogation and Reimbursement Rights of Blue Cross of Idaho

The benefits of this Policy will be available to an Insured when he or she is injured, suffers harm or incurs loss due to any act, omission, or defective or unreasonably hazardous product or service of another person, firm, corporation or entity (hereinafter referred to as “third party”). To the extent that such benefits for Covered Services are provided or paid for by Blue Cross of Idaho under this Policy or any other Blue Cross of Idaho plan, agreement, certificate, contract or policy, Blue Cross of Idaho shall be subrogated and succeed to the rights of the Insured or, in the event of the Insured’s death, to the rights of his or her heirs, estate, and/or personal representative.

As a condition of receiving benefits for Covered Services in such an event, the Insured or his or her personal representative shall furnish Blue Cross of Idaho in writing with the names and addresses of the third party or parties that caused or are responsible, or may have caused or may be responsible for such injury, harm or loss, and all facts and information known to the Insured or his or her personal representative concerning the injury, harm or loss.

Blue Cross of Idaho may at its option elect to enforce either or both of its rights of subrogation and reimbursement.

Subrogation is taking over the Insured’s right to receive payments from other parties. The Insured or his or her legal representative will transfer to Blue Cross of Idaho any rights he or she may have to take legal action arising from the injury, harm or loss to recover any sums paid on behalf of the Insured. Thus, Blue Cross of Idaho may initiate litigation at its sole discretion, in the name of the Insured, against any third party or parties. Furthermore, the Insured shall fully cooperate with Blue Cross of Idaho in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice Blue Cross of Idaho’s subrogation rights and efforts. Blue Cross of Idaho will be reimbursed in full for all benefits paid even if the Insured is not made whole or fully compensated by the recovery.

Additionally, Blue Cross of Idaho may at its option elect to enforce its right of reimbursement from the Insured, or his or her legal representative, of any benefits paid from monies recovered as a result of the injury, harm or loss. The Insured shall fully cooperate with Blue Cross of Idaho in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice Blue Cross of Idaho’s reimbursement rights and efforts.

The Insured shall pay Blue Cross of Idaho as the first priority, and Blue Cross of Idaho shall have a constructive trust and an equitable lien on, all amounts from any recovery by suit, settlement or otherwise from any third party or parties or from any third party’s or parties’ insurer(s), indemnitor(s) or underwriter(s), to the extent of benefits provided by Blue Cross of Idaho under this Policy, regardless of how the recovery is allocated (i.e., pain and suffering) and whether the recovery makes the Insured whole. Thus, Blue Cross of Idaho will be reimbursed by the Insured, or his or her legal representative, from monies recovered as a result of the injury, harm or loss, for all benefits paid even if the Insured is not made whole or fully compensated by the recovery.

To the extent that Blue Cross of Idaho provides or pays benefits for Covered Services, Blue Cross of Idaho’s rights of subrogation and reimbursement extend to any right the Insured has to recover from the Insured’s insurer, or under the Insured’s “Medical Payments” coverage or any “Uninsured Motorist,” “Underinsured Motorist,” or other similar coverage provisions, and workers’ compensation benefits.

Blue Cross of Idaho shall have the right, at its option, to seek reimbursement from, or enforce its right of subrogation against, the Insured, the Insured’s personal representative, a special needs trust, or any trust,
person or vehicle that holds any payment or recovery from or on behalf of the Insured including the Insured’s attorney.

Blue Cross of Idaho’s subrogation and reimbursement rights shall take priority over the Insured’s rights both for expenses already incurred and paid by Blue Cross of Idaho for Covered Services, and for benefits to be provided or payments to be made by Blue Cross of Idaho in the future on account of the injury, harm or loss giving rise to Blue Cross of Idaho’s subrogation and reimbursement rights. Further, Blue Cross of Idaho’s subrogation and reimbursement rights for incurred expenses and/or future expenses yet to be incurred are primary and take precedence over the rights of the Insured, even if there are deficiencies in any recovery or insufficient financial resources available to the third party or parties to totally satisfy all of the claims and judgments of the Insured and Blue Cross of Idaho.

Collections or recoveries made in excess of such incurred Blue Cross of Idaho expenses shall first be allocated to such future Blue Cross of Idaho expenses, and shall constitute a special Deductible applicable to such future benefits and services under this or any subsequent Blue Cross of Idaho policy. Thereafter, Blue Cross of Idaho shall have no obligation to make any further payment or provide any further benefits until the benefits equal to the special Deductible have been incurred, delivered, and paid by the Insured.

XXIII. Independent Blue Cross and Blue Shield Plans
The Group (on behalf of itself and its participants) hereby expressly acknowledges its understanding this Policy constitutes a contract solely between the Group and BCI, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting BCI to use the Blue Cross and Blue Shield Service Marks in the state of Idaho, and that BCI is not contracting as the agent of the Association. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Policy based upon representations by any person, entity or organization other than BCI and that no person, entity or organization other than BCI shall be held accountable or liable to the Group for any of BCI's obligations to the Group created under this Policy. This paragraph shall not create any additional obligations whatsoever on the part of BCI other than those obligations created under other provisions of this Policy.

XXIV. Statements
In the absence of fraud, all statements made by an applicant or the policyholder or by an enrolled person shall be deemed representations and not warranties, and no statement made for the purpose of acquiring insurance shall void such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the enrolled person.

XXV. Membership, Voting, Annual Meeting and Participation
The Group, as the policyholder, is a member of BCI and is entitled to vote in person or by proxy at meetings of policyholders. The Group shall designate to BCI in writing the person who shall have the right to vote in person or by proxy on behalf of the Group. The annual meeting of policyholders of BCI shall be held on the last Friday of April of each year at 2:00 p.m., at the corporation's registered office, 3000 East Pine Avenue, Meridian, Idaho. This notice shall be sufficient as to notification of such annual meetings. If any dividends are distributed, the policyholders shall share in them according to the articles of incorporation and bylaws of BCI and under the conditions set by the board of directors of BCI.

XXVI. Replacement Coverage
If this Policy replaces prior group coverage within sixty (60) days of the date of termination of prior coverage, BCI shall immediately cover all employees and dependents validly covered under the prior coverage at the date of termination who meet BCI’s eligibility requirements and who would otherwise be eligible for coverage under this Policy, regardless of any exclusions or limitations relating to active employment or nonconfinement.

The previous paragraph is subject to all other provisions of Idaho Code Section 41-2215, including BCI’s right to deduct from any benefits becoming payable under this Policy the amount of benefits under the prior Group coverage pursuant to an extension of benefits provision for Insureds who are Totally Disabled.

XXVII. Coverage and Benefits Determinations
BCI is vested with authority and discretion to determine eligibility for coverage and whether a claim for benefits is covered under the terms of this Policy, based on all the terms and provisions set forth in this Policy, and also to determine the amount of benefits owed on claims which are covered.

XXVII. Coordination Of This Policy’s Benefits With Other Benefits

This Coordination of Benefits (COB) provision applies when an Insured has health care coverage under more than one (1) Contract. Contract is defined below.

The Order of Benefit Determination Rules govern the order in which each Contract will pay a claim for benefits. The Contract that pays first is called the Primary Contract. The Primary Contract must pay benefits in accordance with its policy terms without regard to the possibility that another Contract may cover some expenses. The Contract that pays after the Primary Contract is the Secondary Contract. The Secondary Contract may reduce the benefits it pays so that payments from all Contracts does not exceed one hundred percent (100%) of the total Allowable Expenses.

A. Definitions

1. A Contract is any of the following that provides benefits or services for medical or dental care or treatment. If separate Contracts are used to provide coordinated coverage for members of a group, the separate Contracts are considered parts of the same Contract and there is no COB among those separate contracts.
   a) Contract includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
   b) Contract does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefit for non-medical components of long-term care policies; Medicare supplement policies; Medicare or any other federal governmental plans, unless permitted by law.

Each Contract for coverage under a) or b) is a separate Contract. If a Contract has two (2) parts and COB rules apply only to one (1) of the two (2), each of the parts is treated as a separate Contract.

2. This Contract means, in a COB provision, the part of the Contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Contracts. Any other part of the Contract providing health care benefits is separate from this plan. A Contract may apply one (1) COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, any may apply under COB provision to coordinate other benefits.

3. The Order of Benefit Determination Rules determine whether This Contract is a Primary Contract or Secondary Contract when the Insured has health care coverage under more than one (1)Contract. When This Contract is primary, it determines payment for its benefits first before those of any other Contract without considering any other Contract’s benefits. When This Contract is secondary, it determines its benefits after those of another Contract and may reduce the benefits it pays so that all Contract benefits do not exceed one hundred percent (100%) of the total Allowable Expense.

4. Allowable Expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Contract covering the Insured. When a Contract provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Contract covering the Insured is not an Allowable Expense. In addition, any expense
that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

a) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Contracts provides coverage for private hospital room expenses.

b) If an Insured is covered by two (2) or more Contracts that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

c) If an Insured is covered by two (2) or more Contracts that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees not an Allowable Expense.

d) If an Insured is covered by one (1) Contract that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Contract that provides its benefits or services on the basis of negotiated fees, the Primary Contract’s payment arrangement shall be the Allowable Expense for all Contracts. However, if the provider has contracted with the Secondary Contract to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Contract’s payment arrangement and if the provider’s contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Contract to determine its benefits.

e) The amount of any benefit reduction by the Primary Contract because a covered person has failed to comply with the Contract provisions is not an Allowable Expense. Examples of these types of Contract provisions include second surgical opinions, pre-certificate of admissions, and preferred provider arrangements.

5. Closed Panel Plan is a Contract that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Group, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

6. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

B. Order Of Benefit Determination Rules
When an Insured is covered by two (2) or more Contracts, the rules for determining the order of benefit payments are as follows:

1. The Primary Contract pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Contract.

2. a) Except as provided in Paragraph 2.b) below, a Contract that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Contracts state that the complying Contract is primary.

b) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Contract provided by the Contract holder. Examples of these
types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

3. A Contract may consider the benefits paid or provided by another Contract in calculating payment of its benefits only when it is secondary to that other Contract.

4. Each Contract determines its order of benefits using the first of the following rules that apply:
   a) Non-Dependent or Dependent. The Contract that covers the Insured other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Contract and the Contract that covers the Insured as a dependent is the Secondary Contract. However, if the Insured is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Contract covering the Insured as a dependent; and primary to the Contract covering the Insured as other than a dependent (e.g. a retired employee); then the order of benefits between the two Contracts is reversed so that the Contract covering the Insured as an employee, member, policyholder, subscriber or retiree is the Secondary Contract and the other Contract is the Primary Contract.
   b) Dependent Child Covered Under More Than One Contract. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Contract the order of benefits is determined as follows:
      (1) For a dependent child whose parents are married or are living together, whether or not they have ever been married: The Contract of the parent whose birthday falls earlier in the calendar year is the Primary Contract; or If both parents have the same birthday, the Contract that has covered the parent the longest is the Primary Contract.
      (2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
         i. If a court decree states that one of the parents is responsible for the dependent child’s health care expenses or health care coverage and the Contract of that parent has actual knowledge of those terms, that Contract is primary. This rule applies to Contract year commencing after the Contract is given notice of the court decree;
         ii. If a court decree states that both parents are responsible for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) shall determine the order of benefits;
         iii. If a court decree states both parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;
         iv. If there is no court decree allocating responsibility for the dependent child’s health care expenses or health care coverage, the order of benefits for the child are as follows:
            1. The Contract covering the Custodial Parent;
            2. The Contract covering the spouse of the Custodial Parent;
            3. The Contract covering the non-Custodial Parent; and then
       For a dependent child covered under more than one Contract of individuals who are not the parents of the child, the provisions of Subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.
   c) Active Employee or Retired or Laid-off Employee. The Contract that covers an Insured as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Contract. The Contract covering that same Insured as a retired or laid-off employee is the Secondary Contract. The same would hold true if an Insured is a dependent of an active employee and that same Insured is a dependent of a retired or laid-off employee. If the other Contract does not have this rule, and as a
result, the Contracts do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a) can determine the order of benefits.

d) COBRA or State Continuation Coverage. If an Insured whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Contract, the Contract covering the Insured as an employee, member, subscriber or retiree covering the Insured as a dependent of an employee, member, subscriber or retiree is the Primary Contract and the COBRA or state or other federal continuation coverage is the Secondary Contract. If the other Contract does not have this rule, and as a result, the Contracts do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a) can determine the order of benefits.

e) Longer or Shorter Length of Coverage. The Contract that covered the Insured as an employee, member, policyholder, subscriber, or retiree longer is the Primary Contract and the Contract that covered the Insured the shorter period of time is the Secondary Contract.

f) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Contracts meeting the definition of Contract. In addition, This Contract will not pay more than it would have paid had it been the Primary Contract.

C. Effect On The Benefits Of This Contract

A. When This Contract is secondary, it may reduce its benefits so that the total benefits paid or provided by all Contracts during a Contract year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Contract will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Contract that is unpaid by the Primary Contract. The Secondary Contract may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Contract, the total benefits paid or provided by all Contracts for the claim do not exceed the total Allowable Expenses for that claim. In addition, the Secondary Contract shall credit to its Contract deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Contract and other Closed Panel Plans.

D. Facility Of Payment

A payment made under another Contract may include an amount that should have been paid under This Contract. If it does, BCI may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Contract. BCI will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

E. Right Of Recovery

If the amount of the payments made by BCI is more than it should have paid under this COB provision, it may recover the excess from one or more of the Insureds it has paid or for whom it has paid; or any other Insured or organization that may be responsible for the benefits or services provided for the covered Insured. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.
In witness whereof, BLUE CROSS OF IDAHO HEALTH SERVICE, INC., by its duly authorized officer, has executed this Policy.

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Rex Warwick, CHC
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